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9 **BEFORE THE**
BOARD OF REGISTERED NURSING
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. *2013-212*

13 **MARCELITO VIZCONDE CARLOS**
14 **5202 Soledad Mountain Road**
San Diego, CA 92109

A C C U S A T I O N

15 **Registered Nurse License No. 648466**

16 Respondent.

17
18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
21 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
22 Consumer Affairs.

23 2. On or about November 22, 2004, the Board of Registered Nursing issued Registered
24 Nurse License Number 648466 to Marcelito Vizconde Carlos (Respondent). The Registered
25 Nurse License was in full force and effect at all times relevant to the charges brought herein and
26 will expire on May 31, 2014, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2725 of the Code states:

....

(b) The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

....

(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

....

7. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

1 (1) Incompetence, or gross negligence in carrying out usual certified or
2 licensed nursing functions.

3
4 (d) Violating or attempting to violate, directly or indirectly, or assisting in or
5 abetting the violating of, or conspiring to violate any provision or term of this chapter
6 [the Nursing Practice Act] or regulations adopted pursuant to it.

7 REGULATORY PROVISIONS

8 8. California Code of Regulations, title 16, section 1442, states:

9 As used in Section 2761 of the code, "gross negligence" includes an extreme
10 departure from the standard of care which, under similar circumstances, would have
11 ordinarily been exercised by a competent registered nurse. Such an extreme departure
12 means the repeated failure to provide nursing care as required or failure to provide
13 care or to exercise ordinary precaution in a single situation which the nurse knew, or
14 should have known, could have jeopardized the client's health or life.

15 9. California Code of Regulations, title 16, section 1443, states:

16 As used in Section 2761 of the code, "incompetence" means the lack of
17 possession of or the failure to exercise that degree of learning, skill, care and
18 experience ordinarily possessed and exercised by a competent registered nurse as
19 described in Section 1443.5.

20 10. California Code of Regulations, title 16, section 1443.5 states:

21 A registered nurse shall be considered to be competent when he/she
22 consistently demonstrates the ability to transfer scientific knowledge from social,
23 biological and physical sciences in applying the nursing process, as follows:

24 (1) Formulates a nursing diagnosis through observation of the client's physical
25 condition and behavior, and through interpretation of information obtained from the
26 client and others, including the health team.

27 (2) Formulates a care plan, in collaboration with the client, which ensures that
28 direct and indirect nursing care services provide for the client's safety, comfort,
29 hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains
the health treatment to the client and family and teaches the client and family how to
care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the
subordinates and on the preparation and capability needed in the tasks to be
delegated, and effectively supervises nursing care being given by subordinates.

1 (5) Evaluates the effectiveness of the care plan through observation of the
2 client's physical condition and behavior, signs and symptoms of illness, and reactions
3 to treatment and through communication with the client and health team members,
4 and modifies the plan as needed.

5 (6) Acts as the client's advocate, as circumstances require, by initiating action
6 to improve health care or to change decisions or activities which are against the
7 interests or wishes of the client, and by giving the client the opportunity to make
8 informed decisions about health care before it is provided.

9 COST RECOVERY

10 11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
11 administrative law judge to direct a licensee found to have committed a violation or violations of
12 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
13 enforcement of the case.

14 DRUG

15 12. Hydromorphone, also known by the brand name Dilaudid, is a Schedule II controlled
16 substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(J) and is a
17 dangerous drug pursuant to Business and Professions Code section 4022.

18 FACTS

19 13. On or about November 5, 2010, the Board received information from the California
20 Department of Public Health (DPH) that Respondent was among five licensed registered nurses,
21 all employed at Sharp Grossmont Hospital (Sharp) in San Diego, who failed to adhere to the
22 hospital's written policy and procedure in that they all failed to ensure the right medication dose
23 was administered to a patient pursuant to the physician's orders. As a result of the complaint, the
24 Division of Investigation (DOI) conducted an investigation into the allegations.

25 14. Respondent was hired by Sharp on July 22, 2004. As part of his initial and ongoing
26 training, Respondent was responsible for complying with Sharp's Policy and Procedure No.
27 No. 30035.99 entitled "*Medication Administration*." The purpose of the policy and procedure
28 was to provide guidelines for the safe and accurate administration of medications to patients and
proper documentation in the medical record. This policy and procedure contained a Red Rule,
which is a critical behavior in a policy or procedure that is essential to safety. Specifically, in
administering medications, the Red Rule required that staff adhere to the "6 Rights" (right patient,

right drug, right dose, right route, right time, and right rationale). The nursing staff was required to maintain patients' medication history in Cerner, an electronic medication administration record system used by Sharp.¹

15. On the morning of October 15, 2010, a 59-year-old female (hereinafter referred to as Patient 309), presented to the Sharp emergency room complaining of a headache and abdominal pain that radiated to her back. Patient 309 was diagnosed with acute pancreatitis and was admitted as an inpatient at approximately 16:19 hours. At 17:37, the attending physician ordered 0.5 mg hydromorphone every two hours as needed for moderate pain, for a total of four doses. However, the physician entered an order to discontinue the hydromorphone at 18:12. The orders were reviewed and verified by an LVN and a pharmacist.

16. At 18:16 hours, the physician ordered hydromorphone (in a 1 mg. syringe) to be administered intravenously every three hours as needed: 0.4 mg for mild pain, 0.6 mg for moderate pain, and 0.8 mg for severe pain.

17. On October 15, 2010, at 20:29, Respondent assessed Patient 309, who indicated she was in severe pain. Respondent viewed Cerner and saw that there was a physician's order for hydromorphone. Respondent withdrew a 1 mg. syringe of hydromorphone from Pyxis² and administered it to Patient 309 because he believed that the protocol in the Emergency Room was to give 1 mg. hydromorphone for severe pain. When interviewed later, Respondent stated that although he did not look at the order in detail, he assumed the order was for 1 mg.

¹ An Electronic Medication Administration Record (eMAR) is a point-of-care process that utilizes barcode reading technology to monitor the bedside administration of medications. When a nurse uses this technology, medication orders appear electronically in a patient's chart after pharmacist approval. The technology also alerts nurses electronically if a patient's medication is overdue. Before administering medication, a nurse is required to scan the bar codes on the patient's wristband and then those on the medication itself. If the two do not match the approved medication order, or if it is not time for the patient's next dose, a warning is issued.

² "Pyxis" is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, the date and time the medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn medications are administered to the patient. The portions not administered are referred to as "wastage." Wasted medications must be disposed of in accordance with hospital rules and must be witnessed by another authorized user and recorded in Pyxis.

1 hydromorphone instead of .08 mg. Respondent could double-click on any order in Cerner and it
2 would have told him the dosage for each medication ordered.

3 18. Patient 309 was subsequently transferred to Sharp's Nursing Unit (2 East) just after
4 midnight, and was assigned to another nurse's care. At 04:09 hours, Patient 309 was found
5 unresponsive, in asystole ("flatline"), and a Code Blue for cardiac arrest was performed from
6 04:20 to 04:58. Patient 309 was resuscitated, but she had experienced anoxic brain injury and
7 remained unresponsive. Life support was withdrawn on October 18, 2010, and she died that
8 afternoon.

9 19. The Deputy Medical Examiner for San Diego County listed Patient 309's cause of
10 death as arteriosclerotic cardiovascular disease and the manner of death as "natural."

11 20. The Department for Health and Human Services conducted a review of the incident
12 and prepared a summary statement of deficiencies. The report found that as one of five nurses
13 involved in the care of Patient 309 on October 15 and October 16, 2010, Respondent failed to
14 follow written policy and procedure related to medication administration, and failed to ensure that
15 medications were administered in accordance with the orders of the practitioner responsible for
16 the patient's care. "[Respondent] stated that he failed to view the order in its entirety prior to
17 giving the narcotic because he did not 'double click' on the Dilaudid order when viewing it on the
18 eMAR. The double click would have allowed [Respondent] to see the order in its entirety (0.4
19 mg for mild pain; 0.6 mg for moderate pain; 0.8 for severe pain). [Respondent] stated that when
20 he read the initial order containing Dilaudid he 'assumed' it was based on a previously phased out
21 'pain protocol' which permitted a 1 mg dose of Dilaudid to be given based on the patient's
22 perceived level of pain. [Respondent] failed to adhere to the hospital's written policy and
23 procedure titled Medication Administration (#30035.99). Specifically [Respondent] failed to
24 ensure that the right dose was administered to Patient 309 as it was prescribed."

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1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

3 21. Respondent has subjected his registered nurse license to disciplinary action for
4 unprofessional conduct under section 2761, subdivision (a)(1) in that he was grossly negligent, as
5 defined by California Code of Regulations, title 16, section 1442, in that on or about October 15,
6 2010, while employed by Sharp, as detailed in paragraphs 13-20, above, Respondent failed to
7 follow written policies and procedures related to medication administration, and failed to ensure
8 that medications were administered in accordance with physician's orders. Respondent failed to
9 comply with the hospital's Red Rule which required he adhere to the "6 Rights" (right patient,
10 right drug, right dose, right route, right time, and right rationale). Respondent failed to ensure
11 that the right dose was administered to Patient 309 as it was prescribed. Respondent's actions
12 demonstrated an extreme departure from the standard of care that he knew or should have known
13 could have jeopardized the life or health of Patient 309.

14 **SECOND CAUSE FOR DISCIPLINE**

15 **(Incompetence)**

16 22. Respondent has subjected his registered nurse license to disciplinary action for
17 unprofessional conduct under section 2761, subdivision (a)(1) in that he was incompetent, as
18 defined by California Code of Regulations, title 16, section 1442, in that on or about October 15,
19 2010, while employed by Sharp, as detailed in paragraphs 13-21, above, Respondent failed to
20 follow written policies and procedures related to medication administration, and failed to ensure
21 that medications were administered in accordance with physician's orders. Respondent failed to
22 comply with the hospital's Red Rule which required she adhere to the "6 Rights" (right patient,
23 right drug, right dose, right route, right time, and right rationale). Respondent failed to ensure
24 that the right dose was administered to Patient 309 as it was prescribed. Respondent failed to
25 exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a
26 competent registered nurse.

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1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Administering a Controlled Substance in Excess of a Physician's Order)**

3 23. Respondent has subjected his registered nurse license to disciplinary action under
4 section 2761, subdivision (d) of the Code for unprofessional conduct in that Respondent
5 administered to Patient 309 the controlled substance hydromorphone in an amount that exceeded
6 the physician's order, in violation of Code section 2725, subdivision (b)(2), as detailed in
7 paragraphs 13-21, above.

8 **PRAYER**

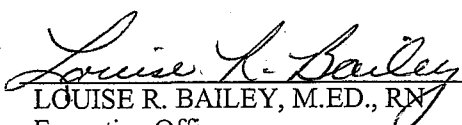
9 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
10 and that following the hearing, the Board of Registered Nursing issue a decision:

11 1. Revoking or suspending Registered Nurse License Number 648466, issued to
12 Marcelito Vizconde Carlos;

13 2. Ordering Marcelito Vizconde Carlos to pay the Board of Registered Nursing the
14 reasonable costs of the investigation and enforcement of this case, pursuant to Business and
15 Professions Code section 125.3;

16 3. Taking such other and further action as deemed necessary and proper.
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19 DATED: September 26, 2012

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21 LOUISE R. BAILEY, M.ED., RN
22 Executive Officer
23 Board of Registered Nursing
24 Department of Consumer Affairs
25 State of California
26 Complainant

27 SD2012703878
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